



## TEXAS DEPARTMENT OF INSURANCE

### Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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## ***MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION GENERAL INFORMATION***

**Requestor Name**

ORTHOTEXAS PHYSICIANS AND SURGEONS

**Respondent Name**

AMERICAN CASUALTY CO OF READING PA

**MFDR Tracking Number**

M4-16-3239-01

**Carrier's Austin Representative**

Box Number 47

**MFDR Date Received**

JUNE 23, 2016

### ***REQUESTOR'S POSITION SUMMARY***

**Requestor's Position Summary:** "After an E&M audit it has been established that CPT 99204 is supported by documentation. See the attached E&M Audit form. Please reprocess this claim for payment immediately."

**Amount in Dispute:** \$400.00

### ***RESPONDENT'S POSITION SUMMARY***

**Respondent's Position Summary:** "The provider has not met the AMA CPT guidelines for CPT 99204, which require these 3 key components be met...A Comprehensive History-Requirement met. A Comprehensive Examination-Requirement NOT met. Medical decision making of Moderate complexity – Requirement met."

**Response Submitted by:** Law Offices of Brain J. Judis

### ***SUMMARY OF FINDINGS***

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 7, 2015	CPT Code 99204 New Patient Office Visit	\$400.00	\$249.61

### ***FINDINGS AND DECISION***

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 effective March 1, 2008, sets the reimbursement guidelines for the disputes service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - B12-Services not documented in patient's medical records.
  - P12-Workers compensation jurisdictional fee schedule adjustment.
  - V122-The level of E&M code submitted is not supported by documentation.
  - Z710-The charge for this procedure exceeds the fee schedule allowance.
  - V298-Documentation on the CMS1500 or UB04 is not supported by the information in the medical record.
  - After review of the bill and the medical record, this service is best described by 99203. Submitted documentation did not meet the 3 key components required for 99204. Lacking a comprehensive physical

examination.

- W3-Additional reimbursement made on reconsideration.
- 193-Original payment decision is being maintained. This claim was processed properly the first time.

### **Issues**

Does the documentation support billing CPT code 99204 on the disputed date of service? Is the requestor entitled to reimbursement?

### **Findings**

28 Texas Administrative Code §134.203(b) states "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers..."

CPT code 99204 is defined as "Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family."

A review of the submitted report supports a complete examination of the lumbar spine; therefore, the requestor supported billing CPT code 99204. As a result, reimbursement is recommended.

Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

(1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32.

(2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of \$50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the \$51.90 (with the exception of surgery) Division conversion factor in 2007."

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

The 2015 DWC conversion factor for this service is 56.2.

The Medicare Conversion Factor is 35.9335

Review of Box 32 on the CMS-1500 the services were rendered in zip code 75093, which is located in Plano, Texas; therefore, the Medicare participating amount is based on locality "Rest of Texas".

The Medicare participating amount for code 99204 is \$159.60

Using the above formula, the MAR is \$162.86. The Division finds the requestor is due \$249.61.

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is \$249.61.

## ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$249.61 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

### Authorized Signature

_____	_____	09/02/2016
Signature	Medical Fee Dispute Resolution Officer	Date

## YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**